

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1640

CERTIFICATE OF DEATH

01091

Reg. Dist. No. 187

1. PLACE OF DEATH:

County HARFORD
City or town CHURCHVILLE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD. County HARFORD
City or town CHURCHVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No. (if rural, give LOCATION) No
2.(a) If veteran, name war No

3. (a) FULL NAME

LOUIS THOMAS ANDREWS

3. (b) Social Security Number

No

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower
6.(b) Name of husband or wife Cenith Andrews
Head 8.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) March 18, 1866
8. AGE: Years 80 Months 6 Days 10 If less than one day _____ hrs. _____ min.
9. Birthplace Alleghany Co., N.C.
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business Carpenter
12. Name Robert Andrews
13. Birthplace Alleghany Co., N.C.
14. Maiden name Unknown
15. Birthplace

16. Informant Mr. J. H. Andrews
Address Edgewood, Md.
17. Burial Date thereof April 29, 1947
(Burial, cremation, or other) (month) (day) (year)
Cemetery or crematory Farmony Cem.
Location Harford Co., Md.
18. Funeral director H. S. Bailey
Address Arlington, Md.
19. April 28, 1947 Registrar M. H. Kirk
(Date rec'd by registrar)

MEDICAL CERTIFICATION

EST

20. DATE OF DEATH April 27 19 47 at 12:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death _____ DURATION _____

GUNSHOT WOUND LEFT CHEST

Due to _____

Due to _____

Other conditions ARTERIOSCLEROTIC

CARDIO-VASCULAR DISEASE

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 4/27/47

Where did injury occur CHURCHVILLE HARFORD MD
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of Injury 12 G. SHOTGUN Injured at work? No

23. SIGNATURE _____ M. D. or other _____

Address Arden, Md. Date signed 4/29/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REC'D

MAY 12 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

CERTIFICATE OF DEATH

01092

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford
City or town Navre de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

662 Franklin St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County Harford

City or town Navre de Grace
(If outside city or town limits, write RURAL and give nearest town)

Street No. 662 Franklin St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Samuel Edward Baldwin

3. (b) Social Security Number

Yes

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Clara M. Baldwin

6. (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1918

8. AGE: Years 68 Months 6 Days 23 It less than one day hrs. min.

9. Birthplace Harford Co. Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Geo. Finney Baldwin

13. Birthplace Md.

14. Maiden name Anna C. Forsythe

15. Birthplace Md.

16. Informant Mrs. Clara M. Baldwin

Address Navre de Grace, Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 4-12-47
(month) (day) (year)

Cemetery or crematory Angel Hill

Location Navre de Grace, Md.

18. Funeral director R. Madison Mitchell

Address Navre de Grace, Md.

19. Apr. 10 19 47 A. L. Lewis M.D. or other
(Date) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 9 19 47 at 11 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 47 to Apr. 9 19 47

and that I last saw him alive on April 9 19 47

Immediate cause of death Coronary thrombosis

Due to Arterio Sclerosis

Due to Chronic Myocarditis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

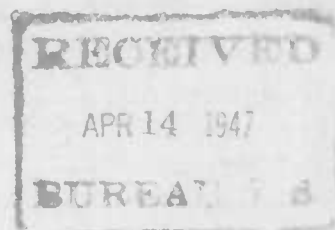
23. SIGNATURE [Signature] M. D. or other

Address Navre de Grace, Md. Date signed 4-10-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01093
Reg. Dist. No. 153

1. PLACE OF DEATH:

County Harford
City or town Shawsville (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 74 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State md County Harford
City or town Shawsville (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Harry Wheeler Berry

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife May Ellen Berry
6.(c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.) Aug 27 1873
8. AGE: Years 74 Months 7 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace Federal Hill Harford Co md
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business _____

FATHER 12. Name Harry Berry
13. Birthplace Harford Co mdMOTHER 14. Maiden name Sallie Billingsley
15. Birthplace Harford Co md16. Informant Mary E Berry
Address White Hall md.17. Burial Date thereof April 6 1947
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory St James, Federal HillLocation Rocks Rd18. Funeral director Marion SkunkAddress Jenns Boule md.19. Apr 6 1947 Thomas R Brown
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 3 19 47 at 11:10 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Apr 3 1947
and that I last saw him alive on Apr 3 1947Immediate cause of death Chronic myocarditis

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE A. M. France M. D. or other _____Address Parkton md. Date signed 4/4/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01094-85

1. PLACE OF DEATH: County..... <u>Harford</u> City or town..... <u>Havre de Grace</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>27 hrs.</u> Hospital, institution, or street address where death occurred: <u>Harford Memorial Hospital</u> How long in hospital or institution?..... <u>27 hrs.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Cecil</u> City or town..... <u>Port Deposit, Rural</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>Francis T. Bitner</u>				3. (b) Social Security Number			
4. Sex <u>Male</u>				5. Color or race <u>White</u>			
6. (a) Single, married, widowed, or divorced <u>Married</u>				6. (b) Name of husband or wife <u>Mary Agnes Bitner</u>			
6. (c) If alive, give age <u>66</u> years				7. Birth date of deceased (mo., day, yr.) <u>August 3, 1873</u>			
8. AGE: <u>73</u>		Years <u>8</u>		Months <u>15</u>		Days <u>hrs.</u> <u>min.</u>	
9. Birthplace <u>Port Deposit, Cecil, Md</u> (Town, county, and state)							
10. Usual occupation <u>Farmer</u>							
11. Industry or business							
FATHER		12. Name <u>Francis T. Bitner</u>					
13. Birthplace <u>Germany</u>		14. Maiden name <u>Alice Kenny</u>					
MOTHER		15. Birthplace <u>Ireland</u>					
16. Informant <u>Mary Agnes Bitner</u> Address <u>Port Deposit, Md. Rural</u>							
17. Burial (Burial, cremation, or removal. Which?) <u>April 21, 1947</u> (month) (day) (year) Cemetery or crematory <u>Brookview</u> Location <u>Rising Sun, Md. Rural</u> 18. Funeral director <u>See a. Patterson & Son</u> Address <u>Perryville, Md.</u>							
19. Date rec'd by registrar <u>Apr. 20</u> 19 <u>47</u> <u>G. L. Lewis M.D.</u> Registrar							
MEDICAL CERTIFICATION 20. DATE OF DEATH <u>April - 18</u> 19 <u>47</u> at <u>11:30 P.M.</u> 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>March 17</u> 19 <u>47</u> to <u>April 8</u> 19 <u>47</u> and that I last saw him alive on <u>April 18</u> 19 <u>47</u> Immediate cause of death <u>Carcinoma of Colon</u> DURATION <u>8 months</u> Due to..... Due to..... Other conditions..... (Include pregnancy within 8 months of death) Major findings of operations <u>Carcinoma of Colon - Ruptured Colon</u> Date of op. <u>Apr 17-1947</u> Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....							
23. SIGNATURE <u>B. J. Benson, M.D.</u> M. D. or other Address <u>Port Deposit Md</u> Date signed <u>4-20-47</u>							

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APR 22 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

CERTIFICATE OF DEATH

01095

Reg. Diat. No. 182

1. PLACE OF DEATH:

County Hartford

City or town Fountain Green Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County Hartford

City or town Jarrettsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Daisy T Buckingham

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife Engene Backingham

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Mar 29 - 1874

8. AGE:

Years

Months

Days

If less than one day

70

0

29

hrs.

min.

9. Birthplace

Pa

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

John H. H. H. H. H.

13. Birthplace

Pa

MOTHER

14. Maiden name

Schwartz

15. Birthplace

Pa

16. Informant

Engene Backingham

Address

Jarrettsville, Md

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

May 1 / 47
(month) (day) (year)

Cemetery or crematory

West Laurel Hill

Location

Philadelphia Pa

18. Funeral director

A. Mercer Quinby

Address

Philadelphia, Pa

19.

April 25 1947

(Date rec'd by registrar)

Boiselle Ferwood

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1947 at 12:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 19 1947 to April 28 1947

and that I last saw her alive on April 27 1947

Immediate cause of death

Cerebral Hemorrhage

DURATION

9 da

Due to

Terminating

Due to

An Essential Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Willard P. Hudson

M. D. or other

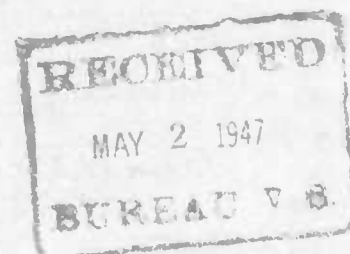
Address Forest Hill Date signed 4/28/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

CERTIFICATE OF DEATH

01096

Reg. Dist. No. 185

1. PLACE OF DEATH

County Harford
City or town Harford
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs.

Hospital, institution, or street address where death occurred:

St. Francis Villa

How long in hospital or institution? 2 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Harford
(If outside city or town limits, write RURAL and give nearest town)

Street No. Market + Commerce
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sister M. Dorinda (Mary G. Cooper)

3. (b) Social Security Number

-

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

6. (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.)

11/16/1876

8. AGE: Years 70 Months 5 Days 13 If less than one day - hrs. - min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)

10. Usual occupation Retired Teacher

11. Industry or business

12. Name John F. Cooper

13. Birthplace Philadelphia, Pa.

14. Maiden name Helena Maus

15. Birthplace Philadelphia, Pa.

16. Informant Hospital Records

Address Market + Commerce Harford

17. Burial Date thereof 5/3/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Redeemed

Location Baltimore, Md.

18. Funeral director Burroughs + Son

Address Harford, Md.

19. May 1 19 47 A. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 19 47 at 11:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1 19 47 to April 29 19 47

and that I last saw him alive on April 29 19 47

Immediate cause of death

DURATION

Pulmonary Tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Harford, Md. Date signed 4/30/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 2 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-21 X

CERTIFICATE OF DEATH

01097

P

Reg. Dist. No.

1. PLACE OF DEATH:

County Harford

City or town Other Point
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Edgewood Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Harford

City or town Other Point
(If outside city or town limits, write RURAL and give nearest town)

Street No. Edgewood Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Barnett Creswell

3. (b) Social Security Number

NONE

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Mamie Creswell

7. Birth date of deceased (mo., day, yr.)

May 19th 1875

6.(c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

71

10

23

hrs.

min.

9. Birthplace

Harford Co. Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Self

FATHER

12. Name

Geo. Wm Creswell

13. Birthplace

Unknown

MOTHER

14. Maiden name

Margaret Dolan

15. Birthplace

Harford Co. Md.

16. Informant

Leue R. Wollschlaeger

Address

1720 Ainsworth St.

17.

(Burial, cremation, or removal. Which?)

Date hereof

(month) (day) (year)

Burial

4/15/47

Cemetery or crematory

Mountain

Location

Harford Co. Md.

18. Funeral director

William Cook Inc.

Address

1217 St. Paul St

19.

(Date rec'd by registrar)

15

4-14-47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947, at MD

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1947 to Apr 1947

and that I last saw him alive on Apr 6 1947

Immediate cause of death Carcinoma of thyroid glands.

DURATION

6 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Protestant Chris M.D.

M. D. or other

Address

Bel Air Md

Date signed 4/12/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

01098

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County Harford
City or town Harford
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 hr
Hospital, institution, or street address where death occurred: Harford Mem Hosp
How long in hospital or institution? 1 1/2 hr

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Harford
City or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No. 403 Ford St
(If rural, give LOCATION)
2.(a) If veteran, name war none

3. (a) FULL NAME

John W. Day, Sr.

3. (b) Social Security Number

217-07-7317

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M

6. (b) Name of husband or wife Hattie M. Cullum

7. Birth date of deceased (mo., day, yr.) Me. 20 1875 6. (c) If alive, give age 60 years

8. AGE: Years 72 Months 1 Days hrs. min.

9. Birthplace Aberdeen, Harford Co., Md.
(Town, county, and state)

10. Usual occupation Day laborer

11. Industry or business

12. Name John A. Day

13. Birthplace Harford Co., Md.

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mrs. John W. Day

Address 403 Ford St. Aberdeen

17. Burial Date thereof April 27 1947
(Burial, cremation, or removal, Which) (month) (day) (year)

Cemetery or crematory Bakers Cemetery

Location Aberdeen, Md.

18. Funeral director Henry Tarrington

Address Aberdeen, Md.

19. Apr. 26 1947 W. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/24 19 47 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/24 19 47, to 4/24 19 47
and that I last saw him alive on 4/24/47 19 47

Immediate cause of death

Coronary Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dwight Phelps M.D. M. D. or other

Address Harford Mem Hosp Date signed 4/24/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 29 1947
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

CERTIFICATE OF DEATH

Reg. Dist. No. 01099

1. PLACE OF DEATH:

County HarfordCity or town Bel Air Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 17 years

Hospital, institution, or street address where death occurred:

Co HomeHow long in hospital or institution? 17 years

3. (a) FULL NAME

John Deulin

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

S

8. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Oct 6 - 1867

8. AGE:

Years

Months

Days

If less than one day

79

.....hrs.min.

9. Birthplace

Unknown

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

James Deulin

13. Birthplace

UNKNOWN

14. Maiden name

Margaret West

15. Birthplace

UNKNOWN16. Informant Co. Home Records

Address

Bel Air, Md

17.

Burial

(Burial, cremation, or removal, Which?)

Date thereof

4/26/47

Cemetery or crematory

Co Home

Location

Bel Air Rural

18. Funeral director

Dean Vint

Address

Bellin Md

19.

(Date rec'd by registrar)

19.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HarfordCity or town Bel Air
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 19. 47 at 9:20 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 24 19. 47 to April 25 19. 47and that I last saw him alive on Apr 24 19. 47

Immediate cause of death

Coronary Thrombosis

DURATION

12 hr.

Due to

Due to

Other conditions

Ch. Myocardial Disease
Gen. Arterio-sclerosis
(Include pregnancy within 3 months of death)

Major findings of operations

.....Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Willard P. Anderson

M. D. or other

Address Forest Hill Md Date signed 4/25/47

RECEIVED

APR 28 1947

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1640

CERTIFICATE OF DEATH

01100

Reg. Dist. No.

183

1. PLACE OF DEATH:

County HarfordCity or town Beltsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HarfordCity or town Beltsville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

JOHN THOMAS DUNCAN

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White Married6.(b) Name of husband or wife Grace Duncan

7. Birth date of

deceased (mo., day, yr.)

6.(c) If alive, give age 45 years

8. AGE:

Years

Months

Days

If less than one day

69 11 10 hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19. 47

Thomas R. Brown

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 19 47, at 11:30 AM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

Gunshot wound of
Face & Skull
Compound fracture
of skull

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 4/4/47Where did injury occur? near Beltsville Harford Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury ShotgunInjured at work? No

23. SIGNATURE

J. R. Ramsey M.D.
Dep. Medical Examiner or other

Address

Abertown Md.

Date signed

4/4/47

RECEIVED
APR 9 1947
BUREAU I D

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1912)

CERTIFICATE OF DEATH

01101

Reg. Dist. No. 181

1. PLACE OF DEATH:

County Hanford
City or town Cherdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 52 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Hanford
City or town Cherdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No. Dalto St. E. 8
(If rural, give LOCATION)
2. (a) If veteran, name war None

3. (a) FULL NAME

Mary F. Hall

3. (b) Social Security Number

None

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Joseph A. Hall 8. (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) March 4th 1895

8. AGE: Years 52 Months 1 Days 3 If less than one day
hrs. min.

9. Birthplace Cherdeen, Hanford Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Nelson, Ethel

13. Birthplace Phila. Pa.

14. Maiden name Lenna Riley

15. Birthplace Maryland

16. Informant Miss Robert Hall
Address Cherdeen Md.

17. Burial Date thereof April 12-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Union M. E.

Location Near Cherdeen Md.

18. Funeral director Henry Tanning Sons
Address Cherdeen Md.

19. Apr. 10 19 47 Nellie F. Riley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8th 1947 at 9:58 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 19 47 to April 8 19 47

and that I last saw him alive on April 7 19 47

Immediate cause of death Uremia

Due to Hypertensive cardiorenal

disorder

Due to

Other conditions Anemia, hypochromic, microcytic, due to uremia
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Walter P. Rodman M.D.
W. H. H. Ave., Aberdeen Md. M. D. or other

Address W. H. H. Ave., Aberdeen Md. Date signed 4/10/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

RECEIVED

APR 16 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47dx

01104

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County HarfordCity or town Belt Air

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County HarfordCity or town Belair

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3 (a) FULL NAME

Robert Haldenorth Heighe

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed or divorced married

6.(b) Name of husband or wife

Anne McGehe7. Birth date of deceased (mo., day, yr.) Feb. 4 1882 6.(c) If alive, give age 60 years8. AGE: Years 65 Months 1 Days 27 If less than one day hrs. min.9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Frederick C. Heighe13. Birthplace Baltimore14. Maiden name Ann Wenchester15. Birthplace Boston Mass.16. Informant Juliet HeigheAddress Bel Air, Maryland.17. (Burial, cremation, or removal. Which?) Burial Date thereof Apr 3 1947

(month) (day) (year)

Cemetery or crematory Green MountLocation Balto Md18. Funeral director Henry W. Jenkins, SonAddress McClure Orchard St.19. April 2 1947 A. W. Jenkins

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 1 1947 at 6:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1943 to Apr 1 1947and that I last saw him alive on Apr 1 1947Immediate cause of death Carcinoma Lung(Primary)

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. W. Jenkins M. D. or otherAddress Belair Md Date signed 4/2/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-2

CERTIFICATE OF DEATH

01105

MV
Reg. Dist. No. 180

1. PLACE OF DEATH: <u>HARFORD</u> County..... City or town..... <u>MAGNOLIA</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <u>ROUTE 40 NEAR MAGNOLIA</u> How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>MD.</u> County..... <u>HARFORD</u> City or town..... <u>MAGNOLIA - RURAL</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>ROUTE 40</u> (If rural, give LOCATION) 2(a) If veteran, name war.....			
3. (a) FULL NAME <u>GEORGE STEVENES HENNING</u>				3. (b) Social Security Number <u>217-01-1538</u>			
4. Sex <u>Male</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Married</u>			
8. (b) Name of husband or wife..... <u>Gertrude Henning</u>				7. Birth date of deceased (mo., day, yr.) <u>Sept. 16 1889</u>			
8. AGE: Years <u>57</u> Months <u>6</u> Days <u>17</u> If less than one day..... hrs. min.				8. (c) If alive, give age..... years			
9. Birthplace..... <u>Long Green, Baltimore Co., Md.</u> (Town, county, and state)				10. Usual occupation..... <u>Operating Engineer</u>			
11. Industry or business..... <u>U.S. Gov. Ordnance Arsenal Md.</u>				12. Name..... <u>Adam Henning</u>			
13. Birthplace..... <u>Germany</u>				14. Maiden name..... <u>Mary Zugler</u>			
15. Birthplace..... <u>Joppa Maryland</u>				16. Informant..... <u>Mrs. Gertrude E. Henning</u>			
Address..... <u>Joppa Maryland</u>				17. Burial, cremation, or removal, which?..... <u>Burial</u> (Burial, cremation, or removal, which?) Date thereof..... <u>Apr. 7, 1947</u> (month) (day) (year) Cemetery or crematory..... <u>St. Stephen's</u> Location..... <u>Bridgetown Maryland</u>			
18. Funeral director..... <u>Howard K. McCombs</u>				Address..... <u>Abingdon Maryland</u>			
19. <u>Apr. 7</u> 19 <u>47</u> <u>Mrs. M. Monks</u> (Date rec'd by registrar) Registrar				20. MEDICAL CERTIFICATION 2D. DATE OF DEATH..... <u>APRIL 3</u> 19 <u>47</u> , at <u>11 P.</u> M. 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19..... and that I last saw h..... alive on..... 19..... Immediate cause of death..... <u>Cerebral Concussion</u> <u>Shock from compound</u> <u>fracture Rt. Tibia & fibula</u> <u>and fracture left tibia</u> <u>& fibula.</u> Due to..... Due to..... Other conditions..... (Include pregnancy within 3 months of death) Major findings of operations..... Date of op..... Autopsy results..... <u>None</u> PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... <u>ACCIDENT</u> Date of <u>4/3/47</u> Where did injury occur?..... <u>NEAR MAGNOLIA HARFORD MD.</u> (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... <u>ROUTE #40</u> Means of injury..... <u>STUCK BY AUTO</u> Injured at work?..... <u>NO</u>			
23. SIGNATURE..... <u>J. Ramsey M.D.</u> Address..... <u>Abingdon, Md.</u> Date signed..... <u>4/4/47</u>				24. <u>Dep. Medical Examiner</u> Address..... <u>Abingdon, Md.</u> Date signed..... <u>4/4/47</u>			

00730

UNITED STATES DEPARTMENT OF JUSTICE

STANDARD FORM NO. 100

OFFICE OF THE ATTORNEY GENERAL
WASHINGTON, D. C.

RECEIVED
APR 10 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 745

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Hartford
 City or town Bell Air, Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 Months
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County
 City or town Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 9 N Broadway
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Frank Hoffman

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

6. (b) Name of husband or wife

Amelia Hoffman

7. Birth date of

deceased (mo., day, yr.) UNKNOWN

6. (c) If alive, give age

1873 years

8. AGE:

Years

Months

Days

If less than one day

74

hrs.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

Isadora Hoffman

13. Birthplace

Russia

MOTHER

14. Maiden name

Lena UNKNOWN

15. Birthplace

Russia

16. Informant

Mrs. Mary Coppel

Address

3 N. Main St

17.

(Burial, cremation, or removal. Which?)

Date thereof

April 13/47
(month) (day) (year)

Cemetery or crematory

Hickman Cemetery

Location

Bell Air, Md

18. Funeral director

Jack Lewis Inc

Address

2100 Euteria PlaceBell Air, Md

19.

(Date rec'd by registrar)

19

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

4/11

19

47

at

615

A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Did not attend to Did not see alive
 and that I last saw him alive on 19

Immediate cause of death

Coronary thrombosis

DURATION

Sudden

Due to

Deceased suffered from
and chronic bronchitis
and old age.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Physician's M.D.
Bell Air, Md
 Address Date signed 4/11/47

RECEIVED

APR 14 1947

BUREAU V B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01106

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford
 City or town Harre de Grace
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 weeks
 Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
 How long in hospital or institution? 10 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Harford
 City or town Harre de Grace
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 662 Green St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Viola May Hopkins

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1871

8. AGE:

Years

Months

Days

If less than one day

75519

hrs.

min.

9. Birthplace

Harford to Md.

(Town, county, and state)

10. Usual occupation

House Keeper

11. Industry or business

FATHER

12. Name

George Hopkins

13. Birthplace

Md.

MOTHER

14. Maiden name

Annie McCummings

15. Birthplace

Md.

16. Informant

Mr. Norman E. Hopkins

Address

Harre de Grace, Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

Apr. 27 1947

Cemetery or crematory

Rock Run

Location

Harford to Md.

18. Funeral director

W. Madison Mitchell

Address

Harre de Grace, Md.

19.

(Date rec'd by registrar)

19

47A. L. Lewis M.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Apr. 24

19

47

at

5:45 P.

M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 27

19

45

to

Apr. 24

19

47

and that I last saw him alive on

Apr. 24

19

47

Immediate cause of death

Coronary Thrombosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. L. Lewis M.

Address

Harre de Grace, Md.

Date signed

4-26-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 29 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

Reg. Dist. No. 01103
787

1. PLACE OF DEATH:

County BaltimoreCity or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)Street No. 6 Post Road
(If rural, give LOCATION)2.(a) If veteran, name war none

3. (a) FULL NAME

Mrs. Fannie Putner

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, or divorced

Married

6. (b) Name of husband or wife

Arson6. (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.)

4/23/1880

8. AGE:

Years

Months

Days

If less than one day

667

hrs.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual occupation

H. W.

11. Industry or business

FATHER

12. Name

David Nefsky

13. Birthplace

Russia

MOTHER

14. Maiden name

Esther Yessanoff

15. Birthplace

Russia

16. Informant

Arson & Hietner

Address

6 Post Road Aberdeen Md

17.

(Burial, cremation, or removal, Which?)

Date thereof

May 2-47
(month) (day) (year)

Cemetery or crematory

Wheaton Ave

Location

White Pa

19. Funeral director

Henry S. Harris Sons

Address

Aberdeen Md

19.

(Date rec'd by registrar)

19.

47Nellie F. Riley

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30th 1947, at 2:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June1946to Apr 301947and that I last saw him alive on Apr 30th 1947

Immediate cause of death

cardiac decompositionchronic myocarditis

Due to

chronic bronchitis

Due to

chronic emphysema

DURATION

10 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Thos. P. Thompson

M. D. or other

Address

Aberdeen Md

Date signed

Apr 30/47

RECEIVED

MAY 3 1947

BUREAU 3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 72

01107

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:

County Harford
City or town Forest Hill
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 year 4 months
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Kutz

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Bessie Robinson

7. Birth date of deceased (mo., day, yr.)

May 5 1883

6. (c) If alive, give age..... years

8. AGE:

Years 63 Months 11 Days 7 If less than one day..... hrs. min.

9. Birthplace

Maryland Line Balto Co Md
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Retired

FATHER

12. Name

Adam E Kutz

13. Birthplace

York Co Pa

MOTHER

14. Maiden name

Elizabeth Thompson

15. Birthplace

York Co Pa

16. Informant

John A Kutz
Address Forest Hill Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Apr 10 1947
(month) (day) (year)

Cemetery or crematory

Deer Creek Chesapeake

Location

Harford Co Md

18. Funeral director

Martin Skrutz
Address Jarvisville Md

19. Date rec'd by registrar

Apr 15 1947 Registrar Thomas P Brown

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HarfordCity or town Forest Hill Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947 at 12 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1946 to April 12 1947and that I last saw him alive on April 11 1947

Immediate cause of death

Coronary Thrombosis

DURATION

30 min

Due to

Due to

Other conditions

Hypertension, Essential 3 yrs -

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Willard P. Hudson
Address Forest Hill Md Date signed 4/13/47

MARGIN RESERVED FOR BINDING

VS A15

9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 22 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01108

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford
 City or town Whiteford
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 70 yrs.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford
 City or town Whiteford
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

William Arthur Lloyd

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Agnes Lloyd

7. Birth date of deceased (mo., day, yr.)

May 1 - 18766. (c) If alive, give age 67 years

8. AGE:

Years

Months

Days

If less than one day

70119

hrs.

min.

9. Birthplace

Harford Co. Md.
(Town, county, and state)

10. Usual occupation

Slater

11. Industry or business

FATHER

12. Name

Robert Lloyd

13. Birthplace

Hales

MOTHER

14. Maiden name

Mary Davis

15. Birthplace

Hales

16. Informant

Agnes Lloyd

Address

Whiteford, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Apr. 17, 1947
(month) (day) (year)

Cemetery or crematory

State Ridge cemetery

Location

Delta, Pa.

18. Funeral director

Robert P. Jachura

Address

Delta, Pa.

19. Date rec'd by registrar

April 14, 1947
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947 at 6:50 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1946, to April 9 1947and that I last saw him alive on April 9 1947Immediate cause of death uraemia

DURATION

Due to chronic nephritis

Due to

Other conditions coronary sclerosis,scirrhus of the liver, ascites
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Benjamin J. Jachura

M. D. or other

Address

CHA D I F F

Date signed

4-10-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 12 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

01109

1. PLACE OF DEATH:

County *Harford*City or town *Harre de Grace*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *25 yrs*

Hospital, institution, or street address where death occurred:

117 Market St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *Harford*City or town *Harre de Grace*
(If outside city or town limits, write RURAL and give nearest town)Street No. *117 Market St.*
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Dora Arkle Meager

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

*John Howard Meager*7. Birth date of
deceased (mo., day, yr.)*Dec. 8, 1875*

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

*71**4**0*

hrs.

min.

9. Birthplace

England
(Town, county, and state)

10. Usual occupation

House Duties

11. Industry or business

FATHER

12. Name

Peter Connor

13. Birthplace

England

14. Maiden name

Phillis Hall

15. Birthplace

England

16. Informant

Mrs. M. Jean Roberts

Address

117 Market St. Harre de Grace, Md.

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

Apr. 9, 1947
(month) (day) (year)

Cemetery or crematory

I.O.O.F. Cemetery

Location

Somerset Co. Penn.

18. Funeral director

R. Madison Mitchell

Address

Harre de Grace, Md.

19.

(Date rec'd by registrar)

*Apr. 9, 1947**A. L. Lewis, M.D.*

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 8, 1947, at 12 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to *Apr. 8, 1947*

and that I last saw him alive on

April 8, 1947

Immediate cause of death

*Arteriosclerosis
Cerebral Hemorrhage*

Due to

Forgotten

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles J. Foley, M.D.

M. D. or other

Address

Harre de Grace, Md.

Date signed

4/9/47

MARGIN RESERVED FOR BINDING

VS A15 9-43-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 14 1947

BUREAU 7 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 750

CERTIFICATE OF DEATH

Reg. Dist. No. 1850

01110

1. PLACE OF DEATH:

County Harford
 City or town Harvick Grace
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs

Hospital, institution, or street address where death occurred:

666 Stsigo Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HarfordCity or town Harvick Grace
(If outside city or town limits, write RURAL and give nearest town)Street No. 666 Stsigo St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Amanda Mitchell

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Robert C. Mitchell

7. Birth date of

deceased (mo., day, yr.)

March 28, 19176. (c) If alive, give age 26 years

8. AGE:

Years

Months

Days

If less than one day

8405

hrs.

min.

9. Birthplace

Penn.
(Town, county, and state)

10. Usual occupation

House Duties

11. Industry or business

Wm. Walker

FATHER

12. Name

Wm. Walker

13. Birthplace

Penn.

MOTHER

14. Maiden name

Jenia Artuckle

15. Birthplace

Penn.

16. Informant

Mrs. Lida G. Baker

Address

666 Stsigo, St. Harvick Grace, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Angel Hill

Date thereof

April 5, 1947
(month) (day) (year)

Cemetery or crematory

Harvick Grace Md.

Location

R. Madison Mitchell

18. Funeral director

Harvick Grace Md.

Address

Harvick Grace Md.

19. 4-3-

19. 47

(Date rec'd by registrar)

A. L. Lewis

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 2, 1947, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 2, 1947 to April 2, 1947and that I last saw him alive on April 1, 1947

Immediate cause of death

Cardiac Insufficiency

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

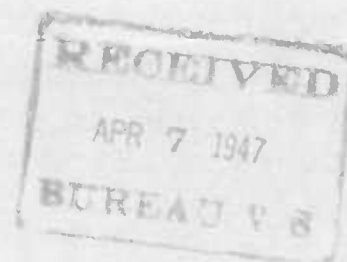
Injured at work?

23. SIGNATURE

A. L. Lewis M. D. or other

Address

Harvick Grace Md.Date signed 4-3-47



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16404

CERTIFICATE OF DEATH

Reg. Dist. No. 01118-1

1. PLACE OF DEATH:

County Harford

City or town Harvards Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs

Hospital, institution, or street address where death occurred:

Gorens Hill Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Harford

City or town Harvards Grace
(If outside city or town limits, write RURAL and give nearest town)

Street No. Gorens Hill Road

(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3. (a) FULL NAME

Leslie Ray Newman

3. (b) Social Security Number

137-18-0955

4. Sex Male 5. Color or race Black 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife -

8. (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Jan 16, 1895

8. AGE: Years 52 Months 2 Days 27 If less than one day - hrs. - min.

9. Birthplace va
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Charles Newman

13. Birthplace va

14. Maiden name Julia Sutton

15. Birthplace va

16. Informant Mrs. Rda G. Henderson

Address Harvards Grace, Md.

17. Burial Date thereof Apr. 26, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Schantilly

Location Fairfax Co. va

18. Funeral director H. Madison Mitchell

Address Harvards Grace, Md.

19. Apr. 24 19 47 A. L. Terison
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 19 47 8:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

- to -

and that I last saw him - alive on -

Immediate cause of death suicide by hanging

DURATION

Due to -

Due to -

Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -

Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, UN in the following:

Accident, suicide, or homicide suicide Date of 4/23/47

Where did injury occur? Harvards Grace, Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Hanged self Injured at work? no

Dr. G. Palmer md

23. SIGNATURE Dr. G. Palmer md M. D. or other

Address Beltz, Md Date signed 4/27/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100% TP 55% 4A
100% W50% P47 91129 A

100% TP 55% 4A

RECEIVED
APR 26 1947
BUREAU V.E.

100% TP 55% 4A
100% W50% P47 91129 A
100% TP 55% 4A
100% W50% P47 91129 A
100% TP 55% 4A
100% W50% P47 91129 A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 102

CERTIFICATE OF DEATH

01112
Reg. Diat. No. 185-

1. PLACE OF DEATH:

County Harford

City or town Harre de Harre
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Harford

City or town Fallston
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

MARIE MORRIS

3. (b) Social Security Number

4. Sex

F

5. Color or race

C

8.(a) Single, married, widowed, or divorced

M

6.(b) Name of husband or wife

Carlos Morris

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

3/24/88

8. AGE:

Years

Months

Days

It less than one day

59

10

16

hrs.

min.

9. Birthplace

near Abingdon MD
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Neil Curtis

13. Birthplace

MD

14. Maiden name

Harriet Hoover

15. Birthplace

MD

16. Informant

Glynneth Pendu

Address

722 W Franklin St Balto

17.

(Burial, cremation, or removal. Which?)

Date thereof

Apr 12 47
(month) (day) (year)

Cemetery or crematory

Lawrence

Location

Forest Hill

18. Funeral director

Address

Martin E. Knute
Sanctiville MD

19.

(Date rec'd by registrar)

Apr. 10 19 47

A. L. Lewis M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 19 47 at 145P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 5 19 47 to April 9 19 47

and that I last saw him alive on April 9 19 47

Immediate cause of death

Bilateral Congestive Pneumonia

Due to

Congestive Heart Failure

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

pneumonia & pulm. & dema

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Dudley Philip W M. D. or other
Address Harford Mem. Hosp Date signed 4/10/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 14 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford
 City or town Navre de Grace
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HarfordCity or town Navre de Grace
(If outside city or town limits, write RURAL and give nearest town)Street No. 201 Freedom Alley
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Black

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Wm Oliver

7. Birth date of deceased (mo., day, yr.)

Sept. 18796. (c) If alive, give age Deceased years

8. AGE:

Years

Months

Days

If less than one day

70--- hrs. - min.

9. Birthplace

Wash. D.C.
(Town, county, and state)

10. Usual occupation

House Duties

11. Industry or business

Wm. Warren

12. Name

13. Birthplace

Wm.

14. Maiden name

15. Birthplace

Lizzie WarrenMd.

16. Informant

John TalbotNavre de Grace, Md.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

5-3-47
(month) (day) (year)

18. Cemetery or crematory

EsburyHarford Co. Md.

19. Funeral director

Madison MitchellNavre de Grace Md.May 219 47

(Date rec'd by registrar)

W. L. Lewis Jr.Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 30 19 47 at 5:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to Apr. 30 19 47and that I last saw her alive on Apr. 30 19 47Immediate cause of death Coronary thrombosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. J. SimonAddress Navre de Grace M. D. or otherDate signed 5-2-47

RECEIVED

MAY 6 1947

BUREAU V B.

CERTIFICATE OF DEATH

Reg. Dist. No. 185

01114

1. PLACE OF DEATH:

County Harford
City or town Harre de Grace, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 wk
Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
How long in hospital or institution? 1 wk

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County Harford
City or town Harre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

Margaret Osmond

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
6. (b) Name of husband or wife Conyle Osmond (de.)
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) April 30 - 1876
8. AGE: Years 70 Months 11 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace Harre de Grace
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business _____
12. Name Hammond
13. Birthplace Harre de Grace
14. Maiden name Martha Cox
15. Birthplace Harre de Grace

16. Informant Mrs. Willard Day
Address P. Washington St. Harre de Grace
17. Burial Date thereof 4/9/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Angel Hill
Location Harre de Grace
18. Funeral director Livingston & Son
Address Harre de Grace, Md.

19. April 9 19 47 A. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 19 47 at 6:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 19 47 to April 7 19 47
and that I last saw her alive on April 7 19 47

Immediate cause of death Circulatory collapse
DURATION _____
Due to Intestinal obstruction 1 wk
Not due to cancer. Due to mesenteric throm-
Due to embolism Lois. following high
Blood pressure. Cerebr.
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE Dudley Shelly M.D. M. D. or other _____
Address Harford Mem Hosp Date signed 4/8/47

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 11 1947

STANDARD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 928

CERTIFICATE OF DEATH

Reg. Dist. No.

0111581

1. PLACE OF DEATH:

County... Harford
City or town... Aberdeen
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred:

301 Custis St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... HarfordCity or town... Aberdeen
(If outside city or town limits, write RURAL and give nearest town)Street No. 301 Custis
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Eliza J. Rogers

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

John O. Rogers

7. Birth date of deceased (mo., day, yr.)

August 22, 1860

6. (c) If alive, give age years

8. AGE:

Years 86 Months 7 Days If less than one dayhrs. min. 9. Birthplace Baltimore, Balto. Co., Md.
(Town, county, and state)10. Usual occupation At Home

11. Industry or business

12. Name William Stuart13. Birthplace Baltimore, Md.14. Maiden name Unknown15. Birthplace Balto., Md.16. Informant Miss M. Estelle RogersAddress 301 Custis St.17. Burial Burial Date thereof Apr. 14 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt ZionLocation near Bel Air Md.18. Funeral director Henry Taxman & SonsAddress Aberdeen, Md.19. Apr. 12 1947 Nellie H. Riley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 11 1947, at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 31 1947 to Apr. 11 1947and that I last saw him alive on Apr. 11 1947

Immediate cause of death

Mitral insufficiency and
cardiac decompensation

DURATION

Due to

Due to

Other conditions

acute bronchitis
cardiac asthma
(Include pregnancy within 3 months of death)

12 days

12 days

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Thos. P. Thompson M. D. or otherAddress Aberdeen Md Date signed Apr. 11 1947

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 16 1947

G. H. A. 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01116

Reg. Dist. No.

182

1. PLACE OF DEATH:

County Harford
 City or town Charlottesville Aural
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Harford
 City or town Charlottesville Aural
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Eliza A Sampson

3. (b) Social Security Number

No

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife Samuel Sampson

alive 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 24, 1868

8. AGE: Years 78 Months 9 Days 19 If less than one day _____ hrs. _____ min.

9. Birthplace Harford Co., MD10. Usual occupation Housewife11. Industry or business at home12. Name Robert Cantler13. Birthplace Harford Co., MD14. Maiden name Unknown15. Birthplace Harford Co., MD16. Informant Wm. Carrolle BarrowAddress Whitford, MD17. Burial Date thereof April 16, 1947Cemetery or crematory Tabernacle Cem.Location Harford Co. MD18. Funeral director H. S. BaileyAddress Charlottesville, MD19. Date rec'd by registrar April 14, 1947

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 12 1947, to April 13 1947and that I last saw her alive on April 13 1947Immediate cause of death Gentle Asphyxiation ofHeart

DURATION

30 hrsDue to ✓Due to ✓Other conditions ✓

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE E. P. Snodgrass

M. D. or other

Address Charlottesville, MD Date signed 4/14/47

RECEIVED
MAY 12 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

01117

Reg. Dist. No. 183

1. PLACE OF DEATH:

County Harford
 City or town Bel Air (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Harford
 City or town Bel Air (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Florence M. Cann Scarff

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Wm S. Scarff
 7. Birth date of deceased (mo., day, yr.) Nov. 30 1865
 6. (c) If alive, give age 85 years
 8. AGE: Years 81 Months 4 Days 14 It less than one day _____ hrs. _____ min.

8. Birthplace Drellin Harford Co Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Wm E. M. Cann
 13. Birthplace Harford Co Md.

14. Maiden name Amanda Troutman
 15. Birthplace Harford Co Md.

16. Informant Wm Ruth S. Luetzenkirchen
 Address 1307 Wandamen ave Bel Air Md

17. Burial Date thereof Apr 17 - 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Centre
 Location Forest Hill Md.

18. Funeral director Martin E. Kutz
 Address Garrettsville Md.

19. Apr. 17 1947 Thomas P. Brown
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1947 at 10:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to April 14 1947
 and that I last saw him alive on April 14 1947

Immediate cause of death Chronic Myocarditis
 DURATION 3 yrs

Due to _____

Out to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Phirogras M. D. or other

Address Harford Md Date signed 4/16/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

01118

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford
 City or town Pylesville Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford
 City or town Pylesville Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Thomas Sharon

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Ida May Sharon
 6.(c) If alive, give age 70 years
 7. Birth date of deceased (mo., day, yr.) Apr. 4 - 1877
 8. AGE: Years 75 Months 0 Days 16 If less than one day _____ hrs. _____ min.

9. Birthplace Harford Co. Md.
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name John Sharon
 13. Birthplace Harford Co. Md.
 MOTHER 14. Maiden name Elizabeth Fay
 15. Birthplace Harford Co. Md.

16. Informant Mrs. Robert Sullivan
 Address Delta, Pa.

17. Burial Date thereof Apr. 24 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Tabernacle cemetery
 Location Whitford, Md.

18. Funeral director Hubert P. Harkins
 Address Delta, Pa.

19. April 22 1947 M. D. Kirk
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1947, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 13, 1947, to April 20, 1947
 and that I last saw him alive on April 17, 1947

Immediate cause of death Coronary occlusion
 DURATION

Due to arteriosclerotic heart disease 6 mo.

Due to _____

Other conditions none

(Include pregnancy within 8 months of death)

Major findings of operations none

Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Charles D. Toff M.D.

Address Street, Md. Date signed 4/22-47
 M. D. or other

RECEIVED

MAY 12 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 181

I. PLACE OF DEATH:

County Hanford
 City or town Aberdeen
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 38 yrs.
 Hospital, institution, or street address where death occurred:
133 S. Rogers St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Hanford
 City or town Aberdeen
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 133 S. Rogers St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Dr. Rudolph Shaug

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mary Osborn
 8. (c) If alive, give age 60 years
 7. Birth date of deceased (mo., day, yr.) January 19, 1881
 8. AGE: Years 60 Months 3 Days 0 If less than one day
 8. (c) If alive, give age 60 years

9. Birthplace Austria-Hungary
 (Town, county, and state)
 10. Usual occupation Veterinarian

11. Industry or business

12. Name John Shaug

13. Birthplace Austria-Hungary

14. Maiden name Barbara Becker

15. Birthplace Austria-Hungary

16. Informant Mrs. Mary O. Shaug

Address 133 S. Rogers St.

17. Burial Date thereof May 2, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bakers

Location Aberdeen

18. Funeral director Henry Tarrington Sons

Address Aberdeen, Md.

19. May 2 1947 Nellie H. Riky

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1947 at 9:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1942, to April 29, 1947

and that I last saw him alive on April 28 1947

Immediate cause of death Coronary

Infarction

Due to Coronary occlusion

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE EB Jastrow MD

M. D. or other

Address Aberdeen Md. Date signed 5-1-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

01119

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MAY 5 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 44 X

CERTIFICATE OF DEATH

Reg. Diat. No. 180

1. PLACE OF DEATH:

County Harford
City or town Joppa R D
(If outside city or town limits write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, institution, or street address where death occurred
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Harford
City or town Joppa Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Ignatius John Staniewski

3. (b) Social Security Number

2-006-104

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Mary

7. Birth date of deceased (mo., day, yr.) July 22 1873

8. AGE: Years 73 Months 8 Days 17 If less than one day hrs. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual occupation Retired steel worker

11. Industry or business

12. Name in known

13. Birthplace

14. Maiden name in known

15. Birthplace

16. Informant Casimir J. Staniewski

Address 130 N. Jahnys Baltimore 24 Md

17. Buried Date of Apr 12 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Stephen

Location Brookhaven Bldg. Co. Md

18. Funeral director Howard R. McCombs

Address Abingdon Maryland

19. April 11 19 47 Maria M. Mouldale
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 19 47, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 45, to April 19 47, and that I last saw him alive on April 19 47.

Immediate cause of death In testicular hemorrhage

Due to Carcinoma of stomach

Other conditions Arteriosclerosis of

Descent
(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Ralph Harky M.D.

Address Churchville Md Date signed April 10

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 15 1947

W. H. A. J. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

01121

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford
 City or town Bel-air Rural
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Cecil
 City or town Perryville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war No ✓

3. (a) FULL NAME

Euphemia Stewart

3. (b) Social Security Number

No

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife Deat Isaac Stewart7. Birth date of deceased (mo., day, yr.) June 17 1858

8. AGE: Years Months Days If less than one day

88 9 25 _____ hrs. _____ min.

9. Birthplace Washington D.C.
(Town, county, and state)10. Usual occupation At Home11. Industry or business Shopman Liddell12. Name Scottland13. Birthplace Julia Russell14. Maiden name Miss Ella Liddell15. Birthplace Burlington Md16. Informant BurialAddress Burlington Md17. (Burial, cremation, or removal, Which) Date thereof April 15 1947

(month) (day) (year)

Cemetery or crematory Forest Hill CemLocation Cecil Co. Md18. Funeral director H. D. BaileyAddress Burlington Md19. April 12 1947 M. D. Kirk

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947 at 11:30^{am}

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1 1947 to April 12 1947and that I last saw her alive on April 10 1947Immediate cause of death Chr. Myocardial Disease

DURATION

2 yrs

Due to _____

Due to _____

Other conditions Gen. Arterio-sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Willard P. Hudson

M. D. or other

Address Forest Hill, Md Date signed 4/12/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED BY THE UNITED STATES DEPARTMENT OF JUSTICE

U.S. DEPARTMENT OF JUSTICE

RECEIVED BY THE UNITED STATES DEPARTMENT OF JUSTICE

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MAY 12 1947

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01122

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (112)

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County HARFORDCity or town Rural - Joppa.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County HarfordCity or town Joppa - Rural
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Florence Mortimer Tanner

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 1 - 1876 6. (c) If alive, give age years8. AGE: Years 70 Months 10 Days 24 If less than one day hrs. min.9. Birthplace Esranville - N.C.
(Town, county, and state)10. Usual occupation Teacher - Housekeeper

11. Industry or business

12. Name Mortimer David Tanner13. Birthplace Mecklenburg - Va.14. Maiden name Ella Martindale15. Birthplace Raleigh - N.C.16. Informant William H. TannerAddress Joppa, Md17. Burial Date thereof Apr 27 - 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Union ChapelLocation Wilrid - Md.18. Funeral director W. H. ArcherAddress Benson. Md19.
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/24 19 47 at 4:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 41 to 19 47and that I last saw him alive on Apr 24 19 47Immediate cause of death Acute myocardial failure DURATION 3 hrsDue to Chronic Bronchial Asthma 8 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. H. Pen's M. D. or otherAddress Bel Air Md Date signed 4/24/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 28 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *FB X*

CERTIFICATE OF DEATH

Reg. Dist. No. *185*

01123

1. PLACE OF DEATH:

County *Harford*
 City or town *Harford Grace*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *7 yrs*

Hospital, institution, or street address where death occurred:

*716 Ontario St.*How long in hospital or institution? *7*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *MD* County *Harford*City or town *Harford Grace*
(If outside city or town limits, write RURAL and give nearest town)Street No. *716 Ontario St.*
(If rural, give LOCATION)2.(a) If veteran, name war *F*

3. (a) FULL NAME

George Robert Thompson

3. (b) Social Security Number

074-07-6947

4. Sex

Male

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

*Mary Elva Thompson*6. (c) If alive, give age *68* years

7. Birth date of

deceased (mo., day, yr.)

Feb. 14, 1873

8. AGE:

Years	Months	Days	If less than one day
<i>74</i>	<i>2</i>	<i>3</i>	hrs. min.

9. Birthplace

Cecil Co. Md.
(Town, county, and state)

10. Usual occupation

(Amer)

11. Industry or business

Continental Can Co. N.Y.

FATHER

12. Name

Robert Thompson

13. Birthplace

md.

MOTHER

14. Maiden name

Matilda Miller

15. Birthplace

md.

16. Informant

Mr. Mary Elva Thompson

Address

716 Ontario St. Harford Grace Md.

17. Burial

West Nottingham

18. Cemetery or crematory

Cecil Co. Md.

Location

R. Madison Mitchell

19. Funeral director

Harford Grace Md.

Address

Apr. 16 47

20. (Date rec'd by registrar)

W. L. Lewis Jr.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Apr. 14 1947* *3:40 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 2 1945 to *Apr. 14 1947*and that I last saw him/her alive on *Apr. 14 1947*

Immediate cause of death

*Uremia*Due to *Carcinoma of prostate*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

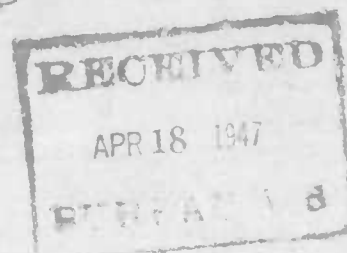
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

*W. L. Lewis Jr.*Address *Harford Grace Md.*Date signed *4-16-47*



Child lived 8 hours and 50 Minutes

MARYLAND STATE DEPARTMENT OF HEALTH Birth and Death
CERTIFICATE OF STILLBIRTH Reg. Dist. No. 181

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Harford
 City or town Aberdeen
 (If outside city or town limits, write RURAL and give nearest town)
 Street address, hospital, or institution:
Sta Hosp APG
 Length of mother's stay in County 5 Mo
 (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland
 County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1823 East Ave
 (If RURAL give LOCATION)

3. Name of child Marilinda Vale
 5. Sex F 6. Twin or triplet _____

4. Date of birth 16 April 19 47 Hour 2:00 AM M.
 7. No. of weeks pregnancy 31

FATHER OF CHILD

8. Full name Ramon Vale
 9. Color W 10. Age at time of this birth 29 yrs.
 11. Usual occupation Soldier

MOTHER OF CHILD

12. Full maiden name Lydia Cecilia Delgado
 13. Color W 14. Age at time of this birth 27 yrs.
 15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 2
 (b) How many other children were born alive but are now dead? _____ (c) How many other children were born dead? 0

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of Placenta Praevia

19. Labor: (a) Complications of None
 (b) Induced? No

20. (a) Was there an operation for delivery? No
 (b) State all operations, if any. _____
 (c) Did child die before operation? _____
 During operation? _____

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Prematurity
 (b) Maternal causes Placenta Praevia

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature [Signature]
 (Specify if M.D., midwife, or other)

Address Sta Hospital Aberdeen Bay Rd

23. (a) Burial (b) Date thereof April 17 47
 (Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Bow

24. (a) Funeral director Henry Tanning Sons
 (b) Address Aberdeen Md

25. (a) Apr 17 47 (b) Nellie H. Riley
 (Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)
 The above certificate has been examined by me.

Health Officer, per _____

* See Instruction C on stub.

RECEIVED

APR 18 1947

SECRET

8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:

County Harford
City or town Pylesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County Harford
City or town Pylesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Massie C. Walter

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife Robert L. Walter

7. Birth date of deceased (mo., day, yr.) November 6, 1873 6. (c) If alive, give age 73 years

8. AGE: Years 73 Months 5 Days 21 If less than one day
hrs. min.

8. Birthplace Harford Co. md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Housekeeping

12. Name James Thompson

13. Birthplace Harford Co. md

14. Maiden name Margaret Reynolds

15. Birthplace Pylesville md

16. Informant Robert L. Walter

Address Pylesville md

17. Burial Date thereof April 29, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Paul's

Location St. Paul's md

18. Funeral director Thompson & Sons

Address 1100 E. Grove Rd

19. Apr 29 1947 Thomas R. Brown
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1947 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1940 to April 27 1947

and that I last saw him alive on April 26 1947

Immediate cause of death Cerebral Hemorrhage DURATION 4 days

Due to Hypertensive C. V. Disease

Due to

Other conditions Chronic Myocarditis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Senah A. Hunt M.D. M. D. or other

Address Delta Pa. Date signed 4/28/47

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 22 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95-8

01125

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH: Hartford
County.....
City or town.....Bel Air, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....New York County.....
City or town.....Schenectady
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1906 Campbell Ave
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME Robert L Walter

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M

6. (b) Name of husband or wife Dorothy Walter

7. Birth date of deceased (mo., day, yr.) Nov 25 / 1924 6. (c) If alive, give age..... years

8. AGE: Years 22 Months Days If less than one day..... hrs. min.

9. Birthplace Schenectady NY (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business

12. Name Martin Walter

13. Birthplace NY

14. Maiden name Elmina Tree

15. Birthplace NY

16. Informant Mrs Dorothy Walter

Address 1906 Campbell Ave - Schenectady NY

17. Burial, cremation, or removal. Which? Burial Date thereof April 25 / 47 (month) (day) (year)

Cemetery or crematory Schenectady, NY

Location Schenectady, NY

18. Funeral director Dean J Foster

Address Bel Air, Md

19. (Date rec'd by registrar) 19..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1947 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... to..... and that I last saw him..... alive on.....

Immediate cause of death Acute Cardiac Deletatory

Due to Rheumatic Heart Disease

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. J. Ramsey M.D.
Deputy Medical Examiner

Address Aberdeen, Md. Date signed 4/21/47

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

